FOR OHF USE

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0043778

Facility Name: PAVILION OF FOREST PARK

Address: 8200 WEST ROOSEVELT (Number) FOREST PARK (City) 60130 (Zip Code)

County: COOK

Telephone Number: (708) 488-9850 **Fax #** (708) 488-9870

IDPA ID Number: 364186094001

Date of Initial License for Current Owners: 03/18/98

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) See Accountants' Compilation Report Attached (Date)
(Print Name and Title) EDWARD N. SLACK, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	232	Skilled (SNF)	232	84,680	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	232	TOTALS	232	84,680	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	18,365	2,038	9,084	29,487	8
9	SNF/PED					9
10	ICF	34,604	4,331		38,935	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	52,969	6,369	9,084	68,422	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.80%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 03/23/98

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 03/23/98 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 27 and days of care provided 9,084

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	261,583	26,709	21,785	310,077		310,077	(25,944)	284,133			1
2	Food Purchase		247,356		247,356	(8,395)	238,961	7,398	246,359			2
3	Housekeeping	190,886	52,820		243,706		243,706	(7,733)	235,973			3
4	Laundry	71,738	22,691		94,429		94,429		94,429			4
5	Heat and Other Utilities			282,446	282,446		282,446	(9,260)	273,186			5
6	Maintenance	77,416		186,333	263,749		263,749	131	263,880			6
7	Other (specify):*							5,968	5,968			7
8	**TOTAL General Services**	601,623	349,576	490,564	1,441,763	(8,395)	1,433,368	(29,441)	1,403,927			8
	B. Health Care and Programs											
9	Medical Director			73,000	73,000		73,000		73,000			9
10	Nursing and Medical Records	3,003,350	139,048	195,136	3,337,534		3,337,534	(20)	3,337,514			10
10a	Therapy	97,715	5,829	50,325	153,869		153,869	58	153,927			10a
11	Activities	140,357	12,827	5,181	158,365		158,365	26	158,391			11
12	Social Services	177,033		38,726	215,759		215,759	15	215,774			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							24,300	24,300			15
16	**TOTAL Health Care and Programs**	3,418,455	157,704	362,368	3,938,527		3,938,527	24,379	3,962,906			16
	C. General Administration											
17	Administrative	29,863		105,283	135,146		135,146	36,257	171,403			17
18	Directors Fees											18
19	Professional Services			438,225	438,225	(23,679)	414,546	(315,920)	98,626			19
20	Dues, Fees, Subscriptions & Promotions			77,909	77,909		77,909	(47,384)	30,525			20
21	Clerical & General Office Expenses	70,089	23,388	197,233	290,710		290,710	(15,461)	275,249			21
22	Employee Benefits & Payroll Taxes			760,984	760,984	8,395	769,379	(47,382)	721,997			22
23	Inservice Training & Education			1,513	1,513		1,513		1,513			23
24	Travel and Seminar			2,314	2,314		2,314	1,754	4,068			24
25	Other Admin. Staff Transportation			16,094	16,094		16,094	(15,000)	1,094			25
26	Insurance-Prop.Liab.Malpractice			225,476	225,476		225,476	(8,754)	216,722			26
27	Other (specify):*							35,985	35,985			27
28	**TOTAL General Administration**	99,952	23,388	1,825,031	1,948,371	(15,284)	1,933,087	(375,905)	1,557,182			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,120,030	530,668	2,677,963	7,328,661	(23,679)	7,304,982	(380,967)	6,924,015			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number PAVILION OF FOREST PARK #0043778 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			101,303	101,303		101,303	651,877	753,180			30
31	Amortization of Pre-Op. & Org.			3,883	3,883		3,883	12,710	16,593			31
32	Interest			281,343	281,343		281,343	877,374	1,158,717			32
33	Real Estate Taxes			499,674	499,674	23,679	523,353	(7,307)	516,046			33
34	Rent-Facility & Grounds			1,016,160	1,016,160		1,016,160	(1,011,393)	4,767			34
35	Rent-Equipment & Vehicles			14,754	14,754		14,754	3,476	18,230			35
36	Other (specify):*											36
37	TOTAL Ownership			1,917,117	1,917,117	23,679	1,940,796	526,737	2,467,533			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	196,262	446,239	457,130	1,099,631		1,099,631	(39,837)	1,059,794			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			127,020	127,020		127,020		127,020			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	196,262	446,239	584,150	1,226,651		1,226,651	(39,837)	1,186,814			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,316,292	976,907	5,179,230	10,472,429		10,472,429	105,933	10,578,362			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/02 Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	207,509	30		9
10	Interest and Other Investment Income	(56,791)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(228)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,135)	20		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(121,250)	21		24
25	Fund Raising, Advertising and Promotional	(21,161)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(934)	20		28
29	Other-Attach Schedule	(153,112)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (148,102)		$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	254,035		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 254,035		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 105,933		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

OHF USE ONLY								
48		49		50		51		52

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

PAVILION OF FOREST PARK

ID# 0043778

Report Period Beginning: 01/01/02

Ending: 12/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Prior Period Adjustment (Utility)	$ (3,000)	05	1
2	LLC Fee (Building Co)	(300)	21	2
3	Bank Charges (Building Co)	(148)	21	3
4	IL Council on LTC - COPE Fees	(3,391)	20	4
5	Theft Loss	(2,389)	21	5
6	Bank Charges	(4,978)	21	6
7	Collections	(3,882)	21	7
8	Meals Income	(20)	02	8
9	Miscellaneous Income	(34)	21	9
10	Jury Duty	(17)	10	10
11	Insurance (Deductibles)	(10,000)	26	11
12	Depreciation (Doctor's Office)	(13,527)	30	12
13	Utilities (Doctor's Office)	(8,031)	05	13
14	Real Estate Tax (Doctor's Office)	(10,380)	33	14
15	Maintenance Salary (Doctor's Office)	(2,225)	06	15
16	Housekeeping Salary (Doctor's Office)	(5,486)	03	16
17	Mortgage Interest (Doctor's Office)	(24,531)	32	17
18	Legal Fees (Prior Period)	(1,105)	19	18
19	Depreciation (Prior Year Expense)	(51,241)	30	19
20	State Replacement Tax	(1,800)	21	20
21	Capitalized R&M	(3,191)	06	21
22	Veterans Expense	(3,436)	10	22
23				23
24				24
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97				97
98				98
99				99
100				100
101	**Total**	(153,112)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary					(3,071)	(9,392)	(13,481)					(25,944)	1
2	Food Purchase	(248)		(153)			7,799						7,398	2
3	Housekeeping	(5,486)						(2,247)					(7,733)	3
4	Laundry													4
5	Heat and Other Utilities	(11,031)		1,771									(9,260)	5
6	Maintenance	(5,416)		3,465	11	2,050	21						131	6
7	Other (specify):*				4,089	1,006	873						5,968	7
8	**TOTAL General Services**	(22,181)		5,083	4,100	(15)	(699)	(15,729)					(29,441)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(3,453)		(42)		12,699	13	(9,237)					(20)	10
10a	Therapy				58								58	10a
11	Activities			2	24								26	11
12	Social Services					15							15	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*				22,551	1,749							24,300	15
16	**TOTAL Health Care and Programs**	(3,453)		(40)	22,633	14,463	13	(9,237)					24,379	16
	C. General Administration													
17	Administrative			417	21	35,477	342						36,257	17
18	Directors Fees													18
19	Professional Services	(1,105)		(315,502)			687						(315,920)	19
20	Fees, Subscriptions & Promotions	(27,621)		(19,800)			37						(47,384)	20
21	Clerical & General Office Expenses	(134,781)	448	17,085		101,295	492						(15,461)	21
22	Employee Benefits & Payroll Taxes				(47,382)								(47,382)	22
23	Inservice Training & Education													23
24	Travel and Seminar			1,019			735						1,754	24
25	Other Admin. Staff Transportation			(15,000)									(15,000)	25
26	Insurance-Prop.Liab.Malpractice	(10,000)		1,246									(8,754)	26
27	Other (specify):*				16,716	19,269							35,985	27
28	**TOTAL General Administration**	(173,507)	448	(330,535)	(30,645)	156,041	2,293						(375,905)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(199,141)	448	(325,492)	(3,912)	170,489	1,607	(24,966)					(380,967)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	142,741	454,114	12,209					42,813				651,877	30
31	Amortization of Pre-Op. & Org.		12,710										12,710	31
32	Interest	(81,322)	938,806	13,021					6,869				877,374	32
33	Real Estate Taxes	(10,380)		3,073									(7,307)	33
34	Rent-Facility & Grounds		(1,016,160)	4,748			19						(1,011,393)	34
35	Rent-Equipment & Vehicles			3,449			27						3,476	35
36	Other (specify):*													36
37	TOTAL Ownership	51,039	389,470	36,500			46		49,682				526,737	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(7,437)		(32,400)				(39,837)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers						(7,437)		(32,400)				(39,837)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(148,102)	389,918	(288,992)	(3,912)	170,489	(5,784)	(24,966)	17,282				105,933	45

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		Seet Attached		
				Forest Park Property LLC		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 1,016,160	Forest Park Property, LLC	100.00%	$	$ (1,016,160)	1
2	V	32	Interest Expense		Forest Park Property, LLC	100.00%	938,806	938,806	2
3	V	21	Bank Charges		Forest Park Property, LLC	100.00%	148	148	3
4	V	31	Amortization		Forest Park Property, LLC	100.00%	12,710	12,710	4
5	V	30	Depreciation		Forest Park Property, LLC	100.00%	454,114	454,114	5
6	V	21	LLC Fee		Forest Park Property, LLC	100.00%	300	300	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,016,160			$ 1,406,078	$ * 389,918	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	05	Utilities	$	Care Centers, Inc.	100.00%	$ 1,771	$ 1,771	15
16	V	06	Maintenance		Care Centers, Inc.	100.00%	3,465	3,465	16
17	V	10	Nursing	51	Care Centers, Inc.	100.00%	9	(42)	17
18	V	11	Activities		Care Centers, Inc.	100.00%	2	2	18
19	V	19	Professional Fees	325,820	Care Centers, Inc.	100.00%	10,318	(315,502)	19
20	V	20	Dues and Subscriptions	21,170	Care Centers, Inc.	100.00%	1,370	(19,800)	20
21	V	21	Office & Clerical		Care Centers, Inc.	100.00%	17,085	17,085	21
22	V	24	Travel and Seminar		Care Centers, Inc.	100.00%	1,019	1,019	22
23	V	26	Insurance		Care Centers, Inc.	100.00%	1,246	1,246	23
24	V	30	Depreciation		Care Centers, Inc.	100.00%	12,209	12,209	24
25	V	32	Interest		Care Centers, Inc.	100.00%	13,021	13,021	25
26	V	33	Real Estate Taxes		Care Centers, Inc.	100.00%	3,073	3,073	26
27	V	34	Rent - Building		Care Centers, Inc.	100.00%	4,748	4,748	27
28	V	35	Rent - Equipment & Auto		Care Centers, Inc.	100.00%	3,449	3,449	28
29	V	25	Bus Reimbursement	15,000	Care Centers, Inc.	100.00%		(15,000)	29
30	V	02	Food	153	Care Centers, Inc.	100.00%		(153)	30
31	V	17	Administration		Care Centers, Inc.	100.00%	417	417	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 362,194			$ 73,202	$ * (288,992)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	03	Housekeeping Salary	$	Care Centers, Inc.	100.00%	$	$	15
16	V	06	Maintenance Salary	30,115	Care Centers, Inc.	100.00%	30,126	11	16
17	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	4,089	4,089	17
18	V	10	Nursing Salary	69,887	Care Centers, Inc.	100.00%	69,887		18
19	V	10a	Rehab Salary	50,325	Care Centers, Inc.	100.00%	50,383	58	19
20	V	11	Activity Salary	4,317	Care Centers, Inc.	100.00%	4,341	24	20
21	V	12	Social Service Salary	36,671	Care Centers, Inc.	100.00%	36,671		21
22	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	22,551	22,551	22
23	V	17	Administration Salary	97,559	Care Centers, Inc.	100.00%	97,580	21	23
24	V	21	Office Salary	27,007	Care Centers, Inc.	100.00%	27,007		24
25	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	16,716	16,716	25
26	V	22	Employee Benefits	47,382	Care Centers, Inc.	100.00%		(47,382)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 363,263			$ 359,351	$ * (3,912)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary Salary	$ 8,468	Care Centers, Inc.	100.00%	$ 5,397	$ (3,071)	15
16	V	06	Maintenance Salary		Care Centers, Inc.	100.00%	2,050	2,050	16
17	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	1,006	1,006	17
18	V	10	Nursing Salary		Care Centers, Inc.	100.00%	12,699	12,699	18
19	V	12	Social Service Salary		Care Centers, Inc.	100.00%	15	15	19
20	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	1,749	1,749	20
21	V	17	Administration Salary		Care Centers, Inc.	100.00%	35,477	35,477	21
22	V	21	Office Salary		Care Centers, Inc.	100.00%	101,295	101,295	22
23	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	19,269	19,269	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 8,468			$ 178,957	$ * 170,489	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$ 18,601	Care Centers, Inc. - Health Systems Division	100.00%	$ 2,713	$ (15,888)	15
16	V	02	Food		Care Centers, Inc. - Health Systems Division	100.00%	7,799	7,799	16
17	V	06	Maintenance		Care Centers, Inc. - Health Systems Division	100.00%	21	21	17
18	V	10	Nursing		Care Centers, Inc. - Health Systems Division	100.00%	13	13	18
19	V	17	Administration		Care Centers, Inc. - Health Systems Division	100.00%	342	342	19
20	V	19	Professional Fees		Care Centers, Inc. - Health Systems Division	100.00%	687	687	20
21	V	20	Dues & Subscriptions		Care Centers, Inc. - Health Systems Division	100.00%	37	37	21
22	V	21	Office & Clerical		Care Centers, Inc. - Health Systems Division	100.00%	492	492	22
23	V	24	Travel & Seminar		Care Centers, Inc. - Health Systems Division	100.00%	735	735	23
24	V	34	Rent - Building		Care Centers, Inc. - Health Systems Division	100.00%	19	19	24
25	V	35	Rent - Equipment & Auto		Care Centers, Inc. - Health Systems Division	100.00%	27	27	25
26	V	39	Ancillary Enteral Supplies	13,299	Care Centers, Inc. - Health Systems Division	100.00%	5,862	(7,437)	26
27	V	01	Dietary - Salary		Care Centers, Inc. - Health Systems Division	100.00%	6,496	6,496	27
28	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc. - Health Systems Division	100.00%	873	873	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 31,900			$ 26,116	$ * (5,784)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$ 99,512	XCEL Medical Supply, LLC	100.00%	$ 86,031	$ (13,481)	15
16	V	03	Housekeeping	16,585	XCEL Medical Supply, LLC	100.00%	14,338	(2,247)	16
17	V	10	Nursing	68,184	XCEL Medical Supply, LLC	100.00%	58,947	(9,237)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 184,282			$ 159,316	$ * (24,966)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	Depreciation	$	Vent Lease, LLC.	100.00%	$ 42,813	$ 42,813	15
16	V	32	Interest		Vent Lease, LLC.	100.00%	6,869	6,869	16
17	V	39	Vent Reimbursement	32,400	Vent Lease, LLC.	100.00%		(32,400)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 32,400			$ 49,682	$ * 17,282	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INS.	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 119,959	$ 119,959	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INS.	119,959				(119,959)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 119,959			$ 119,959	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Relative	Administrative	0.00%	See Attached	2.04	2.83%		$		1
2	Melissa Rothner	Owner	Clerical	7.33%	See Attached			Alloc Salary	42	21-7	2
3	David Aronin	Owner	Administrative	0.86%	See Attached	2.09	4.18%	Alloc Salary	3,607	17-7	3
4	Mark Steinberg	Relative	Administrative	0.00%	See Attached	2.09	4.18%	Alloc Salary	1,888	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 5,537		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2202 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	05	Utilities	Patient Days	1,640,756	39	$ 42,470	$	68,422	$ 1,771	1
2	06	Maintenance	Patient Days	1,640,756	39	83,080		68,422	3,465	2
3	10	Nursing	Patient Days	1,640,756	39	205		68,422	9	3
4	11	Activities	Patient Days	1,640,756	39	51		68,422	2	4
5	19	Professional Fees	Patient Days	1,640,756	39	247,437		68,422	10,318	5
6	20	Dues and Subscriptions	Patient Days	1,640,756	39	32,863		68,422	1,370	6
7	21	Office & Clerical	Patient Days	1,640,756	39	409,698		68,422	17,085	7
8	24	Travel and Seminar	Patient Days	1,640,756	39	53,743		68,422	1,019	8
9	26	Insurance	Patient Days	1,640,756	39	29,875		68,422	1,246	9
10	30	Depreciation	Patient Days	1,640,756	39	292,776		68,422	12,209	10
11	32	Interest	Patient Days	1,640,756	39	312,254		68,422	13,021	11
12	33	Real Estate Taxes	Patient Days	1,640,756	39	73,702		68,422	3,073	12
13	34	Rent - Building	Patient Days	1,640,756	39	113,857		68,422	4,748	13
14	35	Rent - Equipment & Auto	Patient Days	1,640,756	39	82,710		68,422	3,449	14
15	17	Administration	Patient Days	1,640,756	39	10,000		68,422	417	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,784,721	$		$ 73,202	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2202 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	03	Housekeeping Salary	Direct Cost			45,667	45,667			1
2	06	Maintenance Salary	Direct Cost			169,934	169,934		30,126	2
3	07	Emp. Ben. - Gen. Serv.	Direct Cost			29,646			4,089	3
4	10	Nursing Salary	Direct Cost			895,582	895,582		69,887	4
5	10a	Rehab Salary	Direct Cost			128,376	128,376		50,383	5
6	11	Activity Salary	Direct Cost			57,201	57,201		4,341	6
7	12	Social Service Salary	Direct Cost			219,790	219,790		36,671	7
8	15	Emp. Ben. - Healthcare	Direct Cost			180,204			22,551	8
9	17	Administration Salary	Direct Cost			1,334,207	1,334,207		97,580	9
10	21	Office Salary	Direct Cost			584,278	584,278		27,007	10
11	27	Emp. Ben. - Gen. Admin.	Direct Cost			267,060			16,716	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,911,943	$ 3,435,033		$ 359,351	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2202 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary Salary	Patient Days	1,640,756	39	129,417	129,417	68,422	5,397	1
2	06	Maintenance Salary	Patient Days	1,640,756	39	49,148	49,148	68,422	2,050	2
3	07	Emp. Ben. - Gen. Serv.	Patient Days	1,640,756	39	24,132		68,422	1,006	3
4	10	Nursing Salary	Patient Days	1,640,756	39	304,530	304,530	68,422	12,699	4
5	12	Social Service Salary	Patient Days	1,640,756	39	354	354	68,422	15	5
6	15	Emp. Ben. - Healthcare	Patient Days	1,640,756	39	41,952		68,422	1,749	6
7	17	Administration Salary	Patient Days	1,640,756	39	850,731	850,731	68,422	35,477	7
8	21	Office Salary	Patient Days	1,640,756	39	2,429,052	2,429,052	68,422	101,295	8
9	27	Emp. Ben. - Gen. Admin.	Patient Days	1,640,756	39	462,069		68,422	19,269	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 4,291,386	$ 3,763,233		$ 178,957	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2202 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Billable Income	2,191,458		182,448		32,583	2,713	1
2	02	Food	Billable Income	2,191,458		834,365		32,583	7,799	2
3	06	Maintenance	Billable Income	2,191,458		1,400		32,583	21	3
4	10	Nursing	Billable Income	2,191,458		850		32,583	13	4
5	17	Administration	Billable Income	2,191,458		23,000		32,583	342	5
6	19	Professional Fees	Billable Income	2,191,458		46,205		32,583	687	6
7	20	Dues & Subscriptions	Billable Income	2,191,458		2,514		32,583	37	7
8	21	Office & Clerical	Billable Income	2,191,458		33,124		32,583	492	8
9	24	Travel & Seminar	Billable Income	2,191,458		49,456		32,583	735	9
10	34	Rent - Building	Billable Income	2,191,458		1,300		32,583	19	10
11	35	Rent - Equipment & Auto	Billable Income	2,191,458		1,830		32,583	27	11
12	39	Ancillary Enteral Supplies	Billable Income	2,191,458		84,436		32,583	5,862	12
13	01	Dietary - Salary	Billable Income	2,191,458		436,887	436,887	32,583	6,496	13
14	07	Emp. Ben. - Gen. Serv.	Billable Income	2,191,458		58,714		32,583	873	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,756,530	$ 436,887		$ 26,116	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Xcel Medical Supply, LLC
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, IL 60202
Phone Number: (847) 328-7600
Fax Number: (847) 328-7615

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Direct Allocation			$	$		$ 86,031	1
2	03	Housekeeping	Direct Allocation						14,338	2
3	10	Nursing	Direct Allocation						58,947	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 159,316	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Vent Lease, LLC
Street Address: 4101 W. Main Street
City / State / Zip Code: Skokie, Illinois 60076
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	Depreciation	Patient Days	343,608	5	$ 215,000	$	68,422	$ 42,813	1
2	32	Interest	Patient Days	343,608	5	34,494		68,422	6,869	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 249,494	$		$ 49,682	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLOYEE BENEFITS GROUP, INC.
Street Address: 2201 W. MAIN ST.
City / State / Zip Code: EVANSTON, IL 60202
Phone Number: (847) 905-4000
Fax Number: (847) 905-4040

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INS.	DIRECT ALLOCATION			$	$		$ 119,959	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 119,959	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Corus Bank		X	Mortgage		06/30/96	$	$ 10,127,374			$ 938,806	1
2	Less Alloc to Dr. Office										(24,531)	2
3												3
4												4
5												5
	Working Capital											
6	Care Centers, Inc.	X		Working Capital				4,985,015			2,578	6
7	Diawa		X	Line of Credit				3,180,744			278,765	7
8												8
9	TOTAL Facility Related						$	$ 18,293,133			$ 1,195,618	9
	B. Non-Facility Related*											
10	See Supplemental Schedule										(36,901)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (36,901)	14
15	TOTALS (line 9+line14)						$	$ 18,293,133			$ 1,158,717	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 0 Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Interest Income						$	$			$ (56,791)	1
2	Care Center Allocation	X									13,021	2
3	Vent Lease Allocation	X									6,869	3
4	Hunter Management											4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ (36,901)	21

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 251,104	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 364,243	2
3. Under or (over) accrual (line 2 minus line 1).		$ 113,139	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 379,228	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$ 23,679	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 516,046	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1997		8
1998	106,522	9
1999	174,076	10
2000	229,261	11
2001	361,170	12

2002 Accrual - 361,170*1.05=379,228
Appeal Cost - Appraisal Fee-$4,000 - Legal Expenses - $19,679
Opening Accrual adjusted for Non-Care Dr. Office $10,380
Allocated from Care Centers-$2,930

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PAVILION OF FOREST PARK COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0043778

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	15-24-100-020-0000	Long Term Care Property	$ 361,170.24	$ 361,170.24
2.	Care Center, Inc.	Allocation	$ 70,261.69	$ 2,930.02
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 431,431.93	$ 364,100.26

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PAVILION OF FOREST PARK COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0043778

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 99,467 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 4

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 125,875
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 16,593
4. Dates Incurred:

Nature of Costs: Closing Costs, Financing Fees
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1995	$ 400,000	1
2	CCI Allocation			2,669	2
3	TOTALS			$ 402,669	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1998	97,160		20	4,858	4,858	21,170	9
10								-		-	10
11								-		-	11
12								-		-	12
13								-		-	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		11,970,992	307,695		598,213	290,518	2,881,895	68
69	Financial Statement Depreciation			25,317			(25,317)		69
70	TOTAL (lines 4 thru 69)		$ 12,068,152	$ 333,012		$ 603,071	$ 270,059	$ 2,903,065	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 12,068,152	$ 333,012		$ 603,071	$ 270,059	$ 2,903,065	1
2	VACUUM PUMP PIPING	1999	1,000		20	50	50	200	2
3	CABLING	1999	863		20	43	43	168	3
4	CABLING	1999	1,535		20	77	77	295	4
5	FIRE SYSTEM UPGRADE	1999	10,000		20	500	500	1,875	5
6	WALLPAPER	1999	885		20	44	44	158	6
7	DRAPES	1999	1,023		20	51	51	183	7
8	MOTOR	1999	3,085		20	154	154	539	8
9	FIRE ALARM PANEL	1999	1,436		20	72	72	252	9
10	PLUMBING RENOV	1999	17,865		20	893	893	3,051	10
11	CABLING	1999	525		20	26	26	89	11
12	CABLING	1999	1,000		20	50	50	171	12
13	CABLING	1999	1,596		20	80	80	267	13
14	COVE BASE	1999	1,570		20	79	79	263	14
15	PLUMBING RENOV	1999	676		20	34	34	113	15
16	OXYGEN LINES	1999	980		20	49	49	159	16
17	PHONE WIRING	1999	936		20	47	47	153	17
18	ELECTRICAL UPGRADE	1999	8,000		20	400	400	1,267	18
19	CABLING	1999	749		20	37	37	114	19
20	VACUUM PUMP	1999	540		20	27	27	106	20
21	PHONES	1999	1,320		20	66	66	226	21
22	SPRINKLER UPGRADE	2000	1,250		20	63	63	189	22
23	FIRE ALARM PANEL	2000	688		20	34	34	102	23
24	TELEPHONE CABLING	2000	656		20	33	33	99	24
25	TELEPHONE CABLING	2000	796		20	40	40	117	25
26	TELEPHONE CABLING	2000	1,740		20	87	87	247	26
27	TELEPHONE CABLING	2000	1,598		20	80	80	227	27
28	HVAC	2000	815		20	41	41	116	28
29	SINAGE	2000	514		20	26	26	74	29
30	CEILING MOUNT	2000	1,100		20	55	55	156	30
31	CEILING MOUNT	2000	859		20	43	43	122	31
32	PLUMBING RENOV	2000	960		20	48	48	132	32
33	PLUMBING RENOV	2000	1,137		20	57	57	157	33
34	TOTAL (lines 1 thru 33)		$ 12,135,849	$ 333,012		$ 606,457	$ 273,445	$ 2,914,452	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 12,135,849	$ 333,012		$ 606,457	$ 273,445	$ 2,914,452	1
2	OUTLETS	2000	1,125		20	56	56	149	2
3	TELEPHONE CABLING	2000	582		20	29	29	77	3
4	WIRING	2000	760		20	38	38	101	4
5	FIRE PANEL	2000	2,608		20	130	130	347	5
6	TELEPHONE CABLING	2000	703		20	35	35	90	6
7	TELEPHONE CABLING	2000	1,335		20	67	67	173	7
8	HVAC	2000	1,101		20	55	55	142	8
9	HEAT ELEMENT	2000	658		20	33	33	85	9
10	TELEPHONE CABLING	2000	1,498		20	75	75	181	10
11	HVAC	2000	1,418		20	71	71	172	11
12	TELEPHONE CABLING	2000	749		20	37	37	86	12
13	TELEPHONE WIRING	2000	656		20	33	33	74	13
14	TELEPHONE WIRING	2000	749		20	37	37	83	14
15	TELEPHONE WIRING	2000	592		20	30	30	68	15
16	PIPING - WATER HEATR	2000	2,680		20	134	134	302	16
17	PAINT	2000	846		20	42	42	95	17
18	PAINT	2000	1,460		20	73	73	164	18
19	VENT REPAIR	2000	587		20	29	29	68	19
20	VENT REPAIR	2000	658		20	33	33	77	20
21	BOILER REPAIR	2000	503		20	25	25	58	21
22	BOILER REPAIR	2000	770		20	39	39	91	22
23	PAINT	2001	552		20	28	28	56	23
24	HVAC	2001	637		20	32	32	64	24
25	PAINT	2001	762		20	38	38	76	25
26	PAINT	2001	1,460		20	73	73	146	26
27	HOT WATER HEATER	2001	2,656		20	133	133	266	27
28	DOORS	2001	3,100		20	155	155	310	28
29	TELEPHONE WORK	2001	1,030		20	52	52	104	29
30	STATION BOARD	2001	934		20	47	47	90	30
31	VOICE MAIL	2001	1,984		20	99	99	190	31
32	CABLES	2001	618		20	31	31	59	32
33	TRANSFORMER	2001	646		20	32	32	61	33
34	TOTAL (lines 1 thru 33)		$ 12,172,266	$ 333,012		$ 608,278	$ 275,266	$ 2,918,557	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 12,172,266	$ 333,012		$ 608,278	$ 275,266	$ 2,918,557	1
2	HEAT EXCHANGE	2001	18,593		20	930	930	1,783	2
3	HVAC	2001	598		20	30	30	58	3
4	HOT WATER LEAK	2001	4,819		20	241	241	462	4
5	TEL WORK	2001	826		20	41	41	75	5
6	HVAC	2001	646		20	32	32	59	6
7	HOT WATER LEAK	2001	691		20	35	35	64	7
8	VALVES	2001	1,210		20	61	61	112	8
9	FIRE ALARM PANEL	2001	654		20	33	33	58	9
10	STATION	2001	934		20	47	47	82	10
11	SUPPRESSOR	2001	1,321		20	66	66	116	11
12	VOICE MAIL	2001	1,984		20	99	99	173	12
13	TEL WORK	2001	691		20	35	35	58	13
14	HVAC	2001	1,351		20	68	68	113	14
15	HVAC	2001	619		20	31	31	52	15
16	WIRING	2001	1,400		20	70	70	117	16
17	HVAC	2001	506		20	25	25	40	17
18	MILLWORK	2001	625		20	31	31	44	18
19	PANEL	2001	729		20	36	36	48	19
20	GARBAGE DISPOSAL	2001	617		20	31	31	41	20
21	MODULE BOARD	2001	1,983		20	99	99	132	21
22	INSTALL EXPENSION TN	2001	3,643		20	182	182	228	22
23	ELEVATOR REPAIR	2001	850		20	43	43	54	23
24	TELEPHONE WIRING	2001	592		20	30	30	38	24
25	SATELLITE INSTALLATN	2001	832		20	42	42	53	25
26	CONDENSOR REPAIR	2001	1,357		20	68	68	79	26
27	TEL WORK	2001	395		20	20	20	23	27
28	TEL WORK	2001	444		20	22	22	26	28
29	BOILER REPAIR	2001	3,201		20	160	160	227	29
30	ELEVATOR REP	2001	1,130		20	57	57	81	30
31	ELECTRICAL WIRING	2002	1,450		20	145	145	145	31
32	TELEPHONE WIRING	2002	641		20	64	64	64	32
33	SECURITY SYSTEM	2002	526		20	53	53	53	33
34	TOTAL (lines 1 thru 33)		$ 12,228,124	$ 333,012		$ 611,205	$ 278,193	$ 2,923,315	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 12,228,124	$ 333,012		$ 611,205	$ 278,193	$ 2,923,315	1
2	BOILER REPAIR	2002	1,224		20	122	122	122	2
3	GENERATOR REPAIR	2002	1,135		20	114	114	114	3
4	ELECTRICAL WIRING	2002	592		20	59	59	59	4
5	TELEPHONE WIRING	2002	535		20	54	54	54	5
6	BOILER ROOM PIPE LEAK	2002	1,138		20	114	114	114	6
7	HOT WATER BOOSTER	2002	1,006		20	101	101	101	7
8	BOILER REPAIR	2002	705		20	65	65	65	8
9	BOILER REPAIR	2002	864		20	79	79	79	9
10	ELECTRICAL WIRING	2002	915		20	76	76	76	10
11	FENCE REPAIRS	2002	694		20	52	52	52	11
12	PLEXIGLASS-4TH FLOOR	2002	501		20	38	38	38	12
13	BOILER	2002	1,400		20	93	93	93	13
14	BOILER	2002	4,230		20	247	247	247	14
15	CAMERA INSTALLATION	2002	7,300		20	852	852	852	15
16	PIPING	2002	745		20	62	62	62	16
17	DOOR CIRCUITS	2002	761		20	63	63	63	17
18	CURTAINS	2002	664		20	11	11	11	18
19	PAINT	2002	3,191		20				19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,255,724	$ 333,012		$ 613,407	$ 280,395	$ 2,925,517	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 12,255,724	$ 333,012		$ 613,407	$ 280,395	$ 2,925,517	1
2									2
3									3
4									4
5									5
6									6
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,255,724	$ 333,012		$ 613,407	$ 280,395	$ 2,925,517	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 12,255,724	$ 333,012		$ 613,407	$ 280,395	$ 2,925,517	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,255,724	$ 333,012		$ 613,407	$ 280,395	$ 2,925,517	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 12,255,724	$ 333,012		$ 613,407	$ 280,395	$ 2,925,517	1
2									2
3									3
4									4
5									5
6									6
7									7
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10									10
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,255,724	$ 333,012		$ 613,407	$ 280,395	$ 2,925,517	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 12,255,724	$ 333,012		$ 613,407	$ 280,395	$ 2,925,517	1
2									2
3									3
4									4
5									5
6									6
7									7
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,255,724	$ 333,012		$ 613,407	$ 280,395	$ 2,925,517	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 12,255,724	$ 333,012		$ 613,407	$ 280,395	$ 2,925,517	1
2									2
3									3
4									4
5									5
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,255,724	$ 333,012		$ 613,407	$ 280,395	$ 2,925,517	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 12,255,724	$ 333,012		$ 613,407	$ 280,395	$ 2,925,517	1
2									2
3									3
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,255,724	$ 333,012		$ 613,407	$ 280,395	$ 2,925,517	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	232		1998	1998	$ 11,806,343	$ 302,727	35	$ 590,317	$ 287,590	$ 2,853,199	4
5			1996			1,110	35	1,237	127		5
6			2002		24,171	45	35	67	22	67	6
7											7
8											8
	Improvement Type**										
9											9
10	Care Center Inc. Allocation			2002		412	20	28	(384)		10
11	Care Center Inc. Allocation			2001		1	20	6	5		11
12	Care Center Inc. Allocation			2000		1	20	3	(2)		12
13	Care Center Inc. Allocation			1999		20	20	39	19		13
14	Care Center Inc. Allocation			1998		8	20	16	8		14
15	Care Center Inc. Allocation			1997		79	20	160	81		15
16	Care Center Inc. Allocation			1996		207	20	317	110		16
17	Care Center Inc. Allocation-Indiana			1997		1	20	26	25		17
18	Care Center Inc. Allocation			1994		10			(10)		18
19	Care Center Inc. Allocation			1993		4			(4)		19
20	Care Center Inc. Allocation			2002	22,380	42	20	93	51	93	20
21											21
22	Forest Park, LLC-Theater			1998	78,828	2,021	20	3,941	1,920	19,048	22
23	Forest Park, LLC-Grout Work			1998	599		20	30	30		23
24	Forest Park, LLC Flooring			1998	1,500		20	75	75		24
25	Forest Park, LLC-Plumbing			1998	2,908		20	146	146		25
26	Forest Park, LLC Cabling			1998	900		20	45	45		26
27	Forest Park, LLC-Flooring			1998	1,350		20	68	68		27
28	Forest Park, LLC-Sign			1998	32,013	1,007	20	1,599	592	9,488	28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 11,970,992	$ 307,695		$ 598,213	$ 290,514	$ 2,881,895	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,347,686	$ 163,569	$ 134,814	$ (28,755)	10	$ 631,013	71
72	Current Year Purchases	49,747	44,363	4,316	(40,047)	10	4,316	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,397,433	$ 207,932	$ 139,130	$ (68,802)		$ 635,329	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Allocated from CCI		2001	$ 5,253	$ 4,726	$ 642	$ (4,084)	10	$ 15,363	76
77										77
78										78
79										79
80	TOTALS			$ 5,253	$ 4,726	$ 642	$ (4,084)		$ 15,363	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$	14,061,079	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	545,670	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	753,179	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	207,509	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	3,576,209	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Vacant Land-1999	$ 55,211	$	$	86
87	Doctor's Office	527,554	13,527		87
88					88
89					89
90					90
91	TOTALS	$ 582,765	$ 13,527	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/02 Ending: 12/31/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6	Care Center Allocation				4,767			6
7	TOTAL				$ 4,767 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 18,229 Description: See Attached
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 198,745	$		$ 198,745	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			57,959			57,959	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			200,426			200,426	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				240,928		240,928	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental			196,262			205,311		401,573	13
14	TOTAL			$ 196,262		$ 457,130	$ 446,239		$ 1,099,631	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/02 Ending: 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 19,000	$ 22,809	1
2	Cash-Patient Deposits	46,412	46,412	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,868,716	2,868,716	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	294,880	294,880	6
7	Other Prepaid Expenses	22,435	22,435	7
8	Accounts Receivable (owners or related parties)	1,049,980		8
9	Other(specify): See Supplemental Schedule	33,107	33,107	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,334,530	$ 3,288,359	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		455,211	13
14	Buildings, at Historical Cost		12,412,725	14
15	Leasehold Improvements, at Historical Cost	258,071	297,340	15
16	Equipment, at Historical Cost	194,805	1,365,219	16
17	Accumulated Depreciation (book methods)	(183,236)	(2,816,128)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		115,447	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(38,130)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule	680	680	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 270,320	$ 11,792,364	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,604,850	$ 15,080,723	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 816,420	$ 816,422	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	46,318	46,318	28
29	Short-Term Notes Payable	5,007,281	5,007,281	29
30	Accrued Salaries Payable	312,957	312,957	30
31	Accrued Taxes Payable (excluding real estate taxes)	28,262	28,262	31
32	Accrued Real Estate Taxes(Sch.IX-B)	379,228	379,228	32
33	Accrued Interest Payable	17,338	17,338	33
34	Deferred Compensation	441	441	34
35	Federal and State Income Taxes	(38,400)	(38,400)	35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule	60,985	60,985	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 6,630,830	$ 6,630,832	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		13,285,851	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule	34,900	34,900	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 34,900	$ 13,320,751	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,665,730	$ 19,951,583	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,060,880)	$ (4,870,860)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,604,850	$ 15,080,723	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,274,047)	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,274,047)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	213,167	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 213,167	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (2,060,880)	24	*

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,681,699	1
2	Discounts and Allowances for all Levels	(3,148,540)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,533,159	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,811,847	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,811,847	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	20	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	50,262	16
17	Sale of Drugs	273,962	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	34,891	19
20	Radiology and X-Ray	8,310	20
21	Other Medical Services	929,944	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,297,389	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	56,791	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 56,791	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	(13,590)	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (13,590)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,685,596	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,441,763	31
32	Health Care	3,938,527	32
33	General Administration	1,948,371	33
	B. Capital Expense		
34	Ownership	1,917,117	34
	C. Ancillary Expense		
35	Special Cost Centers	1,099,631	35
36	Provider Participation Fee	127,020	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,472,429	40
41	**Income before Income Taxes (line 30 minus line 40)****	213,167	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 213,167	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing	1,803	2,089	58,442	27.98	2
3	Registered Nurses	23,827	26,640	370,200	13.90	3
4	Licensed Practical Nurses	49,774	55,812	1,172,764	21.01	4
5	Nurse Aides & Orderlies	122,947	138,359	1,373,680	9.93	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,778	7,634	97,715	12.80	8
9	Activity Director	1,874	2,203	33,303	15.12	9
10	Activity Assistants	13,336	14,374	107,054	7.45	10
11	Social Service Workers	11,094	12,333	177,033	14.35	11
12	Dietician	1,673	1,820	24,981	13.72	12
13	Food Service Supervisor	1,930	2,169	30,445	14.04	13
14	Head Cook					14
15	Cook Helpers/Assistants	24,831	26,945	206,157	7.65	15
16	Dishwashers					16
17	Maintenance Workers	5,088	5,541	77,416	13.97	17
18	Housekeepers	24,335	26,057	190,886	7.33	18
19	Laundry	9,521	10,198	71,738	7.03	19
20	Administrator					20
21	Assistant Administrator	1,469	1,517	29,863	19.69	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,571	7,206	70,089	9.73	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,323	2,408	28,264	11.74	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	309,173	343,305	$ 4,120,030 *	$ 12.00	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	328	$ 13,317	01-03	35
36	Medical Director	Monthly	73,000	09-03	36
37	Medical Records Consultant	Monthly	3,784	10-03	37
38	Nurse Consultant	35	1,750	10-03	38
39	Pharmacist Consultant	Monthly	3,100	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	18	864	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	CCI SALARY		170,944	Various	47
48	Registered Psychologist	34	2,055	10-03	48
49	TOTAL (lines 35 - 48)	415	$ 268,814		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	72	$ 3,533	10-03	50
51	Licensed Practical Nurses	3,004	110,316	10-03	51
52	Nurse Aides	15	1,490	10-03	52
53	TOTAL (lines 50 - 52)	3,090	$ 115,339		53

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Administrator salaries directly allocated from HO			$
		0	
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
Chris Wayer-Management Fees	$ 9,000
CCI Administrator Payroll - (adjusted on page 6)	96,283
TOTAL (agree to Schedule V, line 17, col. 3)	$ 105,283
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
(See Attached)	Professional Fees	$ 14,556
FR&R	Accounting	16,310
Crowe Chizek	Accounting	2,092
Personnel Planners, Inc.	Unemployment Consult.	2,441
Alpha Data Services, Inc	Data Processing	6,330
IIT/Sourcetech	Data Processing	665
Maxsource	Data Processing	1,100
Omnicare of Northern IL	Data Processing	1,050
(See Attached)	Legal	63,862
(See Attached)	Care Centers, Inc.	325,820
Urban Real Estate	Tax Appraisal	4,000
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 438,225

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 110,184
Unemployment Compensation Insurance	48,772
FICA Taxes	315,182
Employee Health Insurance	186,059
Employee Meals	8,395
Illinois Municipal Retirement Fund (IMRF)*	
Pension	42,491
Employee Physicals	1,101
Other Employee Benefits	9,813
TOTAL (agree to Schedule V, line 22, col.8)	$ 721,997

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	800
Health Care Worker Background Check	
(Indicate # of checks performed 291)	2,934
Dues & Subscriptions	9,983
Licenses & Fees	4,210
Classified Advertising	13,126
Advertising & Public Relations	40,196
Yellow Pages	934
Care Center Allocation	1,407
Less: Public Relations Expense	( )
Non-allowable advertising	(42,331)
Yellow page advertising	(934)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 30,525

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	840
Education Expense	1,474
Alloc from Care Centers	1,754
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,068

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PAVILION OF FOREST PARK # 0043778 Report Period Beginning: 01/01/02 Ending: 12/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Aides only**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council on LTC - $11,112.16**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Yrs.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **2,392** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **127,020**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **See Page 11** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **8,395** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **20**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Frost Ruttenberg & Rothblatt, P.C.** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Not Complete**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees